

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Bueno #2	CHAPTER 100.1
Address: 94-916 Kumuao Street, Waipahu, Hawaii 96797	Inspection Date: February 8, 2019 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> No annual TB attestation form for Resident #1.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>On Monday, February 11, 2019, PCG contacted Resident #1's primary doctor and requested an appointment to complete an Annual TB Attestation form for which PCG was given a date of 03/19/19 at 3pm.</p>	<p>03/19/19</p>

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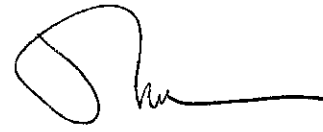
	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(1)(D) Bedrooms:</p> <p>General conditions:</p> <p>Bedrooms shall not be used for recreation, cooking, dining, storage, bathrooms, laundries, foyers, corridors, lanais, and libraries;</p> <p><u>FINDINGS</u> Storage items located in Resident's closets.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>On Sunday, February 10, 2019, PCB along with SCB #1, removed items in Residents' closets being kept there for storage.</p>	<p>02/10/2019</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (e) The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver.</p> <p>FINDINGS No Case Management training record for Substitute Care giver (SCG) #1 and #2.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>On Monday, February 11, 2019, I contacted my Case manager and informed her that my SCG #1 and #2 must com- plete training for residents care as outlined in their individualized care plan. On Monday, February 25, 2019, training for SCG #1 and #2 was performed by case manager</p>	<p>02/25/19</p> <p>19 MAR 21 P2:12</p>

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Licensee's/Administrator's Signature: _____



Print Name: _____

Felicitas B. Caballero

Date: _____

03/20/19

Licensee's/Administrator's Signature: _____



Print Name: _____

Felicitas B. Caballero

Date: _____

May 20, '19

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